



**American Board of Endodontics**

## **Preliminary Application for Certification**

I hereby make application to the American Board of Endodontics, to be declared Board Eligible and to participate in the Certification Process of the American Board of Endodontics.

**Educationally Qualified Endodontist**

An endodontist who has successfully completed and has been issued a certificate in endodontics from an advanced education program in endodontics accredited by the Commission on Dental Accreditation of the ADA.

**Board Eligible Endodontist**

An *Educationally Qualified Endodontist* whose application and credentials have the approval of the Board.

### **Personal Information**

Last Name (Family Name)		First Name		Middle Initial
Street Address	City	State/Province	Zip/Postal Code	Country
E-Mail		Phone (include area or country/city code)		

It is the responsibility of the applicant to keep a current address, email and telephone number on file. Please notify the AAE's Membership Department when any of your contact information changes. The ABE is not responsible for missed communications when the applicant does not have current information on file with the AAE.

### **Education**

Advanced Specialty Education Program in Endodontics	Date and Year Certificate in Endodontics Awarded
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### **Application Processing Instructions**

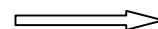
**Please return this application, notarized copy of your Certificate in Endodontics and Track Selection Form along with a Cashier's Check/Money Order/Personal or Business Check made payable to the ABE in the amount of \$250 to:**

**American Board of Endodontics**  
211 East Chicago Avenue Suite 1100  
Chicago, IL 60611-2691

Phone: 800/872-3636 or 312/266-7310

E-Mail: [abe@aee.org](mailto:abe@aee.org)  
[www.aee.org/certboard](http://www.aee.org/certboard)

**over please**



**Please read the following statements carefully and indicate your understanding and agreement by signing below:**

1. I hereby apply to the American Board of Endodontics (ABE) for examination by the ABE and issuance to me of a certificate, in accordance with and subject to the procedures and regulations of the ABE. Under penalty of perjury, I declare that the information that I have provided is true. I have read and agree to the requirements and conditions set forth in the *Policy and Procedures Manual of the American Board of Endodontics* covering the certification process, the administration of certification examinations, and the ABE's policies. I agree to disqualification from examinations, to denial of certification, and to forfeiture and redelivery of any certificate granted me by the ABE in the event that any of the answers or statements made by me in this application are false or in the event that I violate any of the ABE's rules or regulations. I authorize the ABE to make whatever inquiries and investigations it deems necessary to verify my credentials and professional standing.
2. I hereby release the ABE, its members, directors, officers, examiners, and agents from any and all liability arising out of or in connection with any action or omission by any of them in connection with this application, the certification process, any examination or review given by the ABE, any score relating thereto, the failure to issue me a certificate, or any demand for forfeiture or redelivery of such certificate, and I agree to indemnify the ABE and said persons and hold them harmless from any lawsuit, complaint, claim, loss, damage, cost or expense, including attorneys' fees, arising out of or in connection with said certification activities. I UNDERSTAND THAT THE DECISION AS TO WHETHER I QUALIFY FOR A CERTIFICATE RESTS SOLELY AND EXCLUSIVELY WITH THE ABE AND THAT THE DECISION OF THE ABE IS FINAL.
3. I understand that this application and any information or material received or generated by the ABE in connection with this application or with the certification process will be kept confidential and will not be released unless I have authorized such release or such release is required by law. However, I understand that the fact that I have or have not been certified and the effective date of my certification are matters of public record and may be disclosed. Finally, I allow the ABE to use information from my application and subsequent examination for the purpose of statistical analysis, provided that my personal identification with that information has been deleted.
4. I understand that I can be disqualified from taking or continuing to sit for an examination, or from receiving examination scores, and that I may be required to retake an examination if, at its sole discretion, the ABE determines through proctor observation, statistical analysis, or any other means available to it, that I was engaged in collaborative, disruptive, or other irregular behavior before, during the administration of, or following, the examination, or if the ABE determines that the integrity or validity of the examination, otherwise, is in question. I further understand that, in some instances, while the evidence of irregularity is sufficiently strong to cast doubt upon the validity of scores, such evidence may not enable the ABE to identify the particular individuals involved. In any such circumstances, I understand the ABE reserves the right to withhold the scores of all Candidates, including Candidates not directly implicated in the irregularity and, if necessary, to require all Candidates to take an additional examination at a later date under conditions which will ensure the validity of all scores.
5. I understand that the content of the certification examination is proprietary and strictly confidential information. I hereby agree that I will not disclose, either directly or indirectly, any question or any part of any question from the examination to any person or entity. I understand that the unauthorized receipt, retention, possession, copying or disclosure of any examination materials, including but not limited to the content of any examination question, before, during, or after the examination, may subject me to legal action. Such legal action may result in monetary damages and/or disciplinary action including denial or revocation of certification.
6. I understand that this application, and all actions of the ABE or me in connection with the application, examination, certification process, shall be governed by the law of the State of Illinois and that any legal action arising there from shall be brought and tried only in the Circuit Court of Cook County, Illinois.
7. I have read and agree to abide by the ABE Special Accommodations Policy.
8. I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND I INTEND TO BE LEGALLY BOUND BY THEM.

**Applicant's Signature – Your signature must be notarized.**

Name of Applicant \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public My Commission Expires: \_\_\_\_\_ (SEAL)

## The American Board of Endodontics

Certification by the American Board of Endodontics (ABE) helps to assure the public and health professionals that they are being served by an endodontist who has successfully completed a rigorous examination process and remains in good standing in their community on an on-going basis.

For this reason, the ABE requires that you answer each of the following questions. If you answer **Yes** to any of these questions, please provide a full explanation of the answer and return the explanation with this form.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have any disciplinary actions been initiated or are any pending against you by a state licensing board or military tribunal?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Has your license to practice in any state or jurisdiction been denied, relinquished, limited, suspended, reprimanded, censured, or revoked?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program for reasons relating to the practice of dentistry?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has your DEA (narcotics) registration certificate been relinquished, limited, suspended, revoked or challenged?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you been sanctioned, suspended, censured, or expelled from a professional dental or medical organization for reasons other than non-payment of dues?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you been convicted of, been named as a defendant in any criminal proceedings, or pleaded nolo contendere to, any criminal conduct or misdemeanors other than minor traffic violations?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you had hospital or institutional appointments or privileges denied, reduced, limited, not renewed, suspended, diminished, revoked, or relinquished for reasons relating to the practice of dentistry? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

BY SIGNING BELOW, YOU AGREE TO SUPPLEMENT YOUR RESPONSE IF ANY ANSWER TO THE ABOVE QUESTIONS CHANGES IN THE FUTURE.

Date \_\_\_\_\_ Signed \_\_\_\_\_